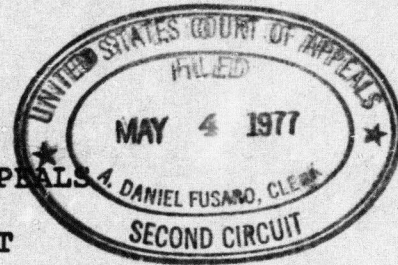


***United States Court of Appeals
for the Second Circuit***



APPENDIX

77-3029



UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

Docket No. 77 -

IN THE MATTER

OF

WILLIAM COOPER

=====

APPENDIX TO PETITION FOR WRIT OF MANDAMUS

=====

ARNOLD WALLACH, ESQ.
Attorney for Petitioner
11 Park Place
New York, New York 10007

Arnold Wallach
Donald E. Nawi,

Of Counsel

DED:RLS:dtj
F. 735043

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

-----X
UNITED STATES OF AMERICA

-vs-

WILLIAM COOPER,

Defendant
-----X

74 CR 333

INDICTMENT

18 U.S.C. §2314

BARTELS, J.
4-29-74

THE GRAND JURY CHARGES:

COUNT I

On or about the 15th day of October, 1973, the defendant WILLIAM COOPER, with unlawful and fraudulent intent, did transport and cause to be transported in interstate commerce from the State of New York in the Eastern District of New York, to the State of Michigan a falsely made and forged security, that is, a bank counter check, knowing the same to be falsely made and forged, said counter check being in the amount of \$12,465.00 and drawn on the City National Bank, Detroit, Michigan, and payable to Franklin Liquidators Corporation.

(Title 18, United States Code, Section 2314)

COUNT II

On or about the 18th day of October, 1973, the defendant WILLIAM COOPER, with unlawful and fraudulent intent, did transport and cause to be transported in interstate commerce from the State of New York, in the Eastern District of New York, to the State of Wisconsin, a falsely made and forged security, that is, a bank counter check, knowing the same to be falsely made and forged, said counter check being in the amount of \$15,650.00 and drawn on the First Wisconsin National Bank, Milwaukee, Wisconsin, and payable to Franklin Liquidators Corporation.

(Title 18, United States Code, Section 2314)

COUNT III

On or about the 24th day of October, 1973, the defendant WILLIAM COOPER, with unlawful and fraudulent intent, did transport and cause to be transported in interstate commerce from the State of New York, in the Eastern District of New York, a falsely made and forged security, that is, a bank counter check, knowing the same to be falsely made and forged, said counter check being in the amount of \$15,375.00, and drawn on the First National Bank of Chicago, Illinois, and payable to Franklin Liquidators Corporation.

(Title 18, United States Code, Section 2314)

A TRUE BILL

FOREMAN

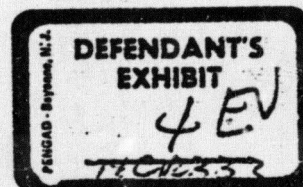
EDWARD J. BOYD 5th
UNITED STATES ATTORNEY

2/28/75
MEMORIAL SLOAN-KETTERING CANCER CENTER
1275 YORK AVENUE, NEW YORK, NEW YORK 10021
(212) 879-3000



November 7, 1974

Frederick H. Block, Esq.
295 Madison Avenue
New York, New York 10017



RE: Mr. William Cooper

Dear Mr. Block:

This letter is in reply to a request for a more detailed medical report regarding Mr. William Cooper.

Mr. Cooper has a rather complicated medical history. In brief, 3 major problems at this time are: severe, intractable chest pain which is mechanical in nature; recurrent polyps of the large bowel with a biopsy diagnosis of carcinoma in situ; a recent history of persistent blood-tinged sputum, the etiology of which has not been determined.

The onset of his chest pain immediately followed a combined thoracic and abdominal surgical procedure in May 1969 for the repair of a massive diaphragmatic herniation of the colon into the chest cavity. The surgery was complicated by extensive pericardial and pleural adhesions and secondary atelectasis of the lower lobe of the left lung. Post-operatively it was noted that he had marked flaring of the left lower rib margin and distention of the left upper abdomen. Fluoroscopic examination indicated decreased movements of the left diaphragm. Because of the severity of the pain, he underwent a second operation in November 1969 in an attempt to stabilize his weakened chest wall as well as to remove the peripheral nerves lying between the partially resected ribs. There was no discernible improvement following this, and his symptoms have continued unchanged up to the present time. The pain is aggravated by postural changes and is most severe in the lying position or when sitting longer than 45 minutes. On examination there is marked tenderness along the entire course of the surgical incision which follows approximately the left T6 dermatome. He was referred to our Pain clinic at the Memorial Sloan-Kettering Cancer Center in an attempt to utilize various therapeutic modalities to alleviate his incapacitating symptoms. So far, none have been successful, in part possibly due to a neurologic deficit in cutaneous sensation on his left side.

Memorial Hospital for Cancer and Allied Diseases
Sloan-Kettering Institute for Cancer Research
Sloan-Kettering Division, Graduate School of Medical Sciences, Cornell University

MEMORIAL SLOAN-KETTERING CANCER CENTER
1275 YORK AVENUE, NEW YORK, NEW YORK 10021
(212) 879-3000



Frederick H. Block, Esq.

Page 2

which is associated with a left-sided weakness. This is thought to be a residual of a cerebrovascular accident which was an additional complication in the 1969 surgical procedure. At any rate, the sensory deficit has severely limited the effective utilization of various mechanical cutaneous stimulators which frequently produce at least temporary relief in chronic pain of this type. In addition, an attempt to produce a nerve block by the injection of alcohol resulted in a severe allergic reaction with respiratory distress. This necessitated hospitalization for stabilization and observation. To date, of the many therapeutic modalities employed, none have been effective in providing significant symptomatic relief.

The other stated major problems, colonic carcinoma and blood-streaked sputum are possibly related. Following routine evaluation for bloody stools, 3 large polyps were removed from the colon in the Spring of 1974. Histologic diagnosis on one of the specimens was carcinoma in situ. Subsequently he has had recurrence of symptoms and has undergone further removal of recurrent polyps. More recently he developed persistent blood-streaked sputum occurring on a daily basis which was initially thought to be related to the severe allergic reaction noted above. However, the persistence of the bleeding has raised the suspicion that he may, in fact, have a more extensive malignant process than originally considered. The extent of his disease has not been determined.

In summary, this is a 63 yo man with a 5 year history of chronic, incapacitating, mechanical chest pain resistant to multiple therapeutic modalities. He is currently being followed for documented malignant changes of the large bowel and is under current evaluation for persistent blood-streaked sputum which may be related to an underlying malignant disease. As stated in my previous letter to you, I do not think that he is able to withstand the physical strain of a court trial at this time.

If I can be of any further assistance to you, please let me know.

Sincerely,

Norman L. Chernik, M.D.
Assistant Attending Neurologist

NLC:amg

MORTON MARKS, M. D.
566 FIRST AVENUE
NEW YORK, NEW YORK 10016
TELEPHONE 679-3200 EXT. 3246

May 13, 1976

Organized Crime Section
Criminal Division
Federal Building
35 Tillary Street
Room 327-A
Brooklyn, New York 11201

Re: WILLIAM COOPER

Dear Mr. Dougherty:

In accordance with your request, William Cooper was again seen in neurological consultation in my office, this time on April 13, 1976. I refer you to my previous report dated March 6, 1975. On the occasion of his last visit the following interval history was obtained.

INTERVAL HISTORY:

The patient states that the pain is becoming worse. He is under the care of Dr. Chernik and is being treated with levo-Dromoran, which he takes every four hours with Tylenol. He takes two or three Seconal capsules at night with Valium. He complains that he is unable to sleep at night. He still is coughing up blood. Hospitalization for a rhizotomy or chordotomy was recommended and he has seen Dr. Dunbar. He is reluctant to have the procedure carried out. He is currently also taking Hygroton. He complains that he has been very depressed. He recently had a recurrence of his bleeding and was operated upon at Mt. Sinai Hospital in September, 1975 and January, 1976.

NEUROLOGICAL EXAMINATION:

A comprehensive neurological examination was again performed. The patient is an obese right handed male. Weight was now 204 lbs. Blood pressure was 170/100. A general physical examination was not performed, however, there was evidence of an irregular pulse. There was still marked tenderness on palpation of the posterior axillary line on

cont./

May 13, 1976

the left side in T6 to T8 dermatomes. There was a left sided weakness and a hemi-hypalgesia and hypesthesia. Snouting was present. There was evidence of a left carotid bruit. Hearing was diminished bilaterally.

REVIEW OF ADDITIONAL MEDICAL RECORDS:

I had the opportunity of reviewing a recent medical record submitted by Dr. Chernik dated April 9, 1976. He felt that Mr. Cooper's general medical condition was deteriorating and that he still showed signs of depression.

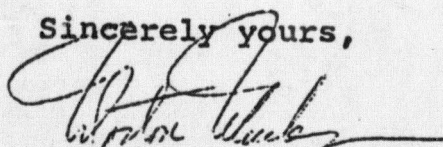
EVALUATION AND OPINION:

From review of the history and present medical status, I would like to submit the following opinion pertaining to Mr. Cooper. The patient still manifests a number of serious medical problems. His primary disability is still that of a severe radiculopathy which is secondary to the prior operations that he had for the repair of a hiatus hernia. His is only minimally controlled with the use of medication. In addition, he has other problems including persistent hemoptysis and problems with his large bowel.

It is still my opinion that Mr. Cooper's medical problems are extremely serious and there has been no significant improvement. I still believe that although his standing trial would pose no serious threat to his life I sincerely believe the physical and emotional strain involved would aggravate and would accentuate the pain and discomfort which he has been coping for many years. I still recommend that he not stand trial at this time. Unfortunately, the overall prognosis from a medical point of view is very poor.

If I can be of further assistance, please do not hesitate to contact me.

Sincerely yours,



MORTON MARKS, M.D.
Diplomate, American Boards
Neurology and Psychiatry

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2 THE CLERK: Defendant's Exhibit 4, a letter,
3 Norman L. Chernik, M.D., dated November 7, 1974 marked
4 for identification.

5 Defendant's Exhibits 1 through 4 is marked in
6 evidence.

7 MR. BLOCK: Now there is some longhand on there
8 that is my longhand. But I am not offering the long-
9 hand obviously.

10 Q Dr. Chernik, these reports that you have made
11 which are now in evidence have stated it as your medical
12 opinion that Mr. Cooper should not stand trial on the criminal
13 charges which are pending against him in this Court. You are
14 aware of that, of course?

15 A Yes.

16 Q Could you give the reasons for that opinion of
17 yours, would you speak slowly and distinctly so the Judge and
18 the Court and Mr. Shanley could follow you.

19 A Well, as outlined in the letters, Mr. Cooper
20 has a long history dating from 1969, a severe contractable
21 pain that has interfered with his ability to maintain his
22 previous activities and has also been resistant to various
23 therapeutic modalities as outlined in the letters.

24 Q What does therapeutic modalities mean, drugs,
25 pain killers?

1
2 A Drugs and also in the case of Mr. Cooper he
3 has had various manipulative procedures performed. Attempted
4 nerve blocks, mechanical vibratory stimulators. He had
5 acupuncture performed at Memorial Sloan Kettering Center.

6 THE COURT: You put all that in the past tense.
7 Is he on drugs now?

8 THE WITNESS: Yes.

9 THE COURT: Is he on pain killers?

10 THE WITNESS: Yes.

11 THE COURT: What drugs is he on?

12 THE WITNESS: He is currently on levo-dromoran
13 which is a synthetic narcotic analgesic. He is on
14 tylenol. He uses these intermittently.

15 THE COURT: What do you mean by intermittently,
16 daily?

17 THE WITNESS: He uses both of them daily but
18 will alternate the narcotic with the tylenol in an
19 attempt to get a better level of pain relief.

20 THE COURT: Do they affect his mental capacity
21 in any way?

22 THE WITNESS: Yes, your Honor. This has been
23 the primary problem in attempting to achieve some sort
24 of pain relief through the use of drugs with Mr. Cooper.
25 And it is not an unusual problem we conquer in patients

1
2 suffering from pain produced by the type of problem
3 that he has. These drugs, especially the narcotic,
4 are known to produce clouding of mentation, lethargy,
5 inability to function properly, and many people are
6 very reluctant to take them on a prolonged basis
7 because of that reason, because of those reasons.

8 Q May I continue? Sir, you talk about his pain.
9 How would you describe his pain, is it intractable pain would
10 you say?

11 A It has been described as such and it is recorded
12 and fairly well documented as such, at least since the time
13 that we have been observing him at Memorial Sloan Kettering
14 Hospital.

15 Q Now Doctor, pain is a subjective thing, isn't
16 it? I mean the patient feels pain and says to the doctor I
17 feel pain. But is there a case in which you can verify the
18 fact that the patient is in pain by the objective conditions
19 from which he suffers?

20 A Yes, definitely. There is no question in my
21 mind that the structural alterations that are clearly docu-
22 mented radiographically occur in a region that is bound to
23 produce the type of pain that Mr. Cooper has. He also has
24 documented neurological deficits. And this is not a subjective
25 phenomenon.

Q Now Doctor I would like you to assume that Mr. Cooper were to be placed on trial in this Court on criminal charges. And that he would be sitting in Court listening to the proof consisting of documentation and witnesses that the Government would call against him. And in view of the conditions which you have described in your letters which are in evidence and what you have just testified to on the witness stand, do you think that Mr. Cooper would be able to assist his attorney in defending himself?

A No, sir, I do not.

Q You do not?

A No.

Q Why is that?

A For two reasons. First of all, the man is suffering severely. This alone, if any of you have ever had the occasion know that when you have severe pain it interferes with your mental capacities. In addition to which he is and has to be maintained on certain pain medication in an attempt to provide partial relief, never complete relief. And one of the problems in that has been further compromises of his capabilities.

Q You mean attempts to dull his mind through medication?

A Yes, sir. And the additional facts which I

1
2 would like to bring out I didn't have a chance to, and one
3 of my concerns in terms of his wellbeing is that chronic pain
4 is known to produce a severe depressive state. Which again,
5 I don't think he is in any psychological condition to think
6 and assist you in the way that he has to. And this is
7 directly a result of his prolonged condition.

8 THE COURT: Could he for a limited period of
9 time, say an hour in the morning and an hour in the
10 afternoon?

11 THE WITNESS: Well, your Honor, the problem I
12 don't think is, the problem is that it is not a matter
13 of duration of time that Mr. Cooper sits in the court-
14 room. The problem is the fact that the duress of having
15 to stand on trial begins before he walks in the doors
16 of the Court.

17 THE COURT: We are talking about at the moment
18 his mental capacity to be able to assist his counsel.
19 And I am saying would he have time, if it was not too
20 long a time, could he for periods of time?

21 THE WITNESS: I do not believe so, your Honor.

22 THE COURT: Do you think apart from his
23 validity to assist his counsel, do you think a trial
24 would have any adverse effects on his present condition?

25 THE WITNESS: I think it certainly would not

1
2 help it. And I think it would adversely affect it.
3 And the pain and depression which he suffers would be
4 aggravated by the mental strain at the trial. There is
5 no question in my mind that it would become even more
6 difficult in terms of overall management. And I try to
7 make that point clear in both of my detailed letters
8 to Mr. Block.

9 THE COURT: There would be no danger to his life
10 as such?

11 THE WITNESS: That is correct, your Honor. I
12 can't say that it would endanger his life. But in
13 answer to Mr. Block's question as to whether he would be
14 able to assist in the matter that he is normally
15 capable of, I do not think he can do that.

16 MR. BLOCK: I have no further questions, your
17 Honor.

18 CROSS-EXAMINATION

19 BY MR. SHANLEY:

20 Q Doctor Chernik, my name is Richard Shanley. I
21 met you before a few minutes before the hearing. I represent
22 the United States Government.

23 When did you first meet Mr. Cooper?

24 A I first met Mr. Cooper I believe at the time of
25 my graduation from medical school, St. Louis University. I

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sort of thing. But what you can do is observe the patient's functional capacity.

Q Can a patient feign pain?

A Not this type of pain, no.

Q Can he feign the severity of the pain?

A To this extent, no.

Q What you are saying then is that the pain that you have observed of Mr. Cooper is of no way feigned?

A Well, sir, in the specialty of my practice we are familiar with not only this type of pain, but also we are familiar with the functional, the neurological deficits that are clearly documented and cannot be feigned because we have numerous ways of examining the patient to verify objectively, per our examination. And this is a very good correlation between neurologic deficit which Mr. Cooper demonstrates and the nature and severity of the pain which he complains of.

Q Pardon my ignorance, what is neurological deficit?

A He has pain in a reticular pattern. And according to that he has a sensory loss that follows a certain pattern which he is not aware of in terms of the anatomy.

Q Sensory loss of hearing?

A No, it has nothing to do with loss of hearing.

2 The body is, the sensory distribution along the body follows
3 a certain pattern according to certain nerves, peripheral
4 nerves. And the patient may feign a certain pain but he is
5 not aware that there is a sensory loss that would be
6 associated with that and the anatomic, the geographic distri-
7 bution of that sensory loss. Most patients will identify
8 a sensory loss if they are feigning between right and left
9 side and submit it at the midline.

10 Mr. Cooper has what is known as a hemi-sensory
11 deficit which covers half of his body. But in addition to
12 that he has a pattern of sensory loss along the trunk which
13 clearly follows the area of the pain which he is complaining
14 of.

15 In other words, there is two distributions to his
16 neurologic deficit.

17 Q I think I comprehend. But what you are saying
18 then, you can tell from this sensory deficit and other
19 examinations the severity of his pain, is that what you are
20 testifying to?

21 A No. But what you can say, he does have a
22 neurologic deficit which is objectively verified, which is
23 consistent with the diagnosis of a reticulopathy and his
24 pain is reticular in nature.

25 Q That reticulopathy means a nerve --

1976 and March 5, 1975. I have them both stapled together and I ask that you mark the whole package as Government's Exhibit 1.

THE CLERK: It will be Government's Exhibit A. Government's Exhibit A, two reports, are marked in Evidence.

MR. SHANLEY: Is there any objection, Mr. Block?

MR. BLOCK: No.

MR. SHANLEY: For the record, I have some handwritten notes here on the side which I will erase, your Honor.

Q And you examined Mr. Cooper on these two occasions, Doctor, and could you in a nutshell tell the Court the results of your examination?

A Yes, Mr. Cooper has several serious medical conditions. From the neurological point of view he does show certain sensory deficits. And he has a persistent pain syndrome that was onset since 1969.

Q Stop there on the pain syndrome. Did you conduct any test to establish the severity of the pain?

A There are no really satisfactory objective measures of the amount of pain that a patient suffers. Some of this is clinical judgment. Some of this is the outward appearance. At times if the pain tends to be an acute type

1 of thing and occurs in short bouts, you may get an elevation
2 of blood pressure capillary changes, but with chronic pain
3 you will frequently not see that type of response. And
4 when the chips are down in the end you have to rely on two
5 things.
6

7 The patient's description of the pain, how reliable
8 a witness he is and how much does it functionally incapacitate
9 him.

10 Q What did you determine or what did you find on
11 using those two criteria?

12 A Well, that he was functioning on a lesser level
13 than he had before 1969. That I believe that this man had
14 a basis for his pain, that is his complaints were valid.
15 I had no objective measure to say at one percentile there
16 is no such thing.

17 Q And you say functioning. Did you notice
18 Mr. Cooper in any way being irrational or out of touch?

19 A No, he was not psychotic or as the laymen would
20 say, he is not nuts.

21 Q He was completely aware of his surroundings?

22 A He was aware of his surroundings, the problems
23 that he had and the consequences of all that he had gone
24 through.

25 Q Between the first time that you saw him in

1 1975 and then a year later in 1976, were you able to evaluate
2 in any way the severity of the pain on each occasion or could
3 you compare the severity of his pain between 1975 and 1976?
4

5 A Objectively, no. Subjectively, I had to
6 depend upon his description of the pain. And he did say
7 that at the time of my second examination in April that his
8 pain was getting worse. That he had now switched from a
9 medication which was, let's say low on the scale of narcotics,
10 to a medication which we would consider a harder drug. And
11 that he was obliged to take this more frequently.

12 Q As a result of your evaluation are you prepared
13 to state your opinion as to whether or not the defendant's
14 life would be in danger if he stood on trial?

15 A I can give an opinion.

16 Q What is that?

17 A His life is not in danger if he stands on trial.

18 Q And with regard to his ability to assist in
19 his own defense, what would your conclusion be as to that?

20 A My conclusion is that he would assist in his
21 own defense with the recognition that when his pain is bad
22 or he has an aggravation or if he is under a large dose of
23 medication at that time, that he may have additional impair-
24 ment. But my recommendation is as a physician, by him
25 standing on trial and I recommend that he not stand on trial,

1
2 is not just on that basis, not permanently on that basis,
3 but as my role as a physician, not as a legal authority.
4 But my problem is to determine how much do I believe that
5 an alleviation of pain and suffering should be considered.
6 And it is on that basis that I made the recommendation that
7 I would recommend from the medical point of view that he not
8 stand trial because the strains, pressures, tensions, physical
9 aspect of this thing in my mind certainly would aggravate
10 his pain. How much, there is no way of knowing.

11 Q Thank you, Doctor.

12 MR. BLOCK: I have no questions, your Honor.

13 THE COURT: As far as assisting in his own
14 defense, as I understand it, as long as he was not
15 under severe pain at a particular time --

16 THE WITNESS: But he is under severe pain. It
17 is a matter of degree.

18 THE COURT: Does this go away like most peoples'
19 pain?

20 THE WITNESS: Frequently, there is a high level
21 of pain but there are times when these things can
22 essentially -- in other words, a thing is never that
23 smooth.

24 THE COURT: And when he is under the most severe
25 attack of pain is it your opinion he cannot assist in

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his defense?

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THE WITNESS: If he says he is in severe pain, I have to accept his description.

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THE COURT: My question is if he is under a severe attack of pain, one of its peaks at that point or points in time, would he be able to assist in his own defense?

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THE WITNESS: It would certainly hamper him significantly.

11

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THE COURT: How often do your records show he must take these narcotic drugs?

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THE WITNESS: Well, I questioned him about that before I came in. When I saw him in April he was taking his medication every four hours. He now tells me he was taking them every two hours.

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THE COURT: And presumably that lasts?

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THE WITNESS: Two hours, I don't know.

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THE COURT: And what effect if any do you think that medication that he is currently taking would have in his capacity to communicate with his counsel?

THE WITNESS: I don't know because I don't know the current dosage. And I have not had the opportunity to examine him and work with him while he is under this type of dosage of drug.

14

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THE COURT: In other words, you didn't give

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him the type of psychiatric exam to enable you to give

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an answer as to whether even when he is under the

4

current dosage, he would be able to communicate

5

adequately with Mr. Block with respect to his defense?

6

THE WITNESS: The problem with this type of

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thing is when you see the patient all you can say

8

is what's going on. I don't know how much pain he

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would have in five hours or two hours from now or how

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effective the drug is, the dosage or whether it is

11

ineffective. And I cannot prophesy when I examine

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the patient. I can just give what I see at that time.

13

But from the series of steps to see how well the

14

patient has been functioning, you get an overall guide.

15

MR. BLOCK: Your Honor, please may I ask a

16

couple of questions.

17

CROSS-EXAMINATION

18

BY MR. BLOCK:

19

Q Doctor, you heard Dr. Chernik testify here.

20

And you heard him testify that his recommendation was based

21

on his experience in actually treating the defendant now

22

over a period of years for some four years. And you heard

23

him say I believe that this intractable pain could interfere

24

with the defendant's concentration during the trial, do you

25

agree with that?

1 A I believe it does interfere with ones ability
2 to concentrate. The problem is I cannot say to what extent.
3

4 Q I understand that. Dr. Chernik said the same
5 thing. You cannot classify it.

6 A That is correct.

7 Q And you also agree with Dr. Chernik that this
8 pain is verifiable objectively?

9 A No pain is not verifiable. There are other
10 associated conditions, so that as pieces of a jigsaw puzzle
11 they all fit in together and point that this man is not a
12 faker. In other words, he has a reality basis. But I don't
13 have an objective measure to say oh now he has 20 percent
14 pain and in an hour from now it is 80 percent pain. And
15 I don't think Dr. Chernik meant to imply that.

16 Q I don't think so.

17 Now, Dr. Chernik also talked about the medication that
18 he is presently getting. But it is true he didn't mention
19 the amount as I recall. Would you agree that the medication
20 is Levo-dromoran?

21 A Levo-dromoran.

22 Q Does that have a tendency to dull the mind?

23 A Like any narcotic.

24 Q And so that when Dr. Chernik gave as one of his
25 reasons that the necessity for this man to take this kind of

1
2 narcotic drug and the fact that such a drug does dull the
3 mind, was one of his reasons for saying that the defendant
4 should not stand trial. And what I am asking you, if you
5 are in general accord with that?

6 A Well, in general we are in accord. We might
7 differ only to the degree because there is no objective
8 finding.

9 Q Did you note in your examination that Mr. Cooper,
10 that he was in a depressed frame of mind?

11 A Yes, he is very depressed.

12 Q Did you hear Dr. Chernik testify that that was
13 another reason why he thought that he would be adversely
14 affected if he were forced to go to trial in a criminal case?

15 A You must excuse, but any time you are depressed
16 it does not help. Again, it is a matter of degree. When you
17 are depressed it does not help you in anything you do.

18 Q But depression is a word of art in a medical
19 profession.

20 A Depression is a diagnostical condition associated
21 with certain mental feelings that can impair one's functional
22 capacity.

23 Q And you found that condition in the defendant?

24 A This man is depressed.

25 Q Now, just one second. Sir, I would like you to

-E/th

3

Q And I ask you if you agree with Dr. Chernik that that does have a dull effect on the mind?

A I would say again particularly, it may very well have a dulling effect on the mind. Everyone has a different threshold and unfortunately, the same person at times will have a dulling effect or an effective dose and at other times it is ineffective.

MR. BLOCK: I have nothing further.

THE COURT: All right, Doctor, you may step down.

Well, I take it we can treat this under section 4244 Title 18, because in effect that is what it is to determine whether he has a medical capacity to stand trial. And as the record stands now, I don't know whether it is sufficient. What I would like to do is order the record or have the Government order the record. And I would like you to submit the record, Mr. Shanley, to your experts in Washington and get their views on it. And I would like to study the record myself. And then I think I will determine whether or not I want him to be committed to Kings County or some other hospital for some period of time for a further examination.

MR. SHANLEY: I was going to suggest that to the Court, that it might be an alternative to see that --

1 THE COURT: I am certainly not convinced one way
2 or the other that he cannot stand on trial. Although,
3 I think there might be some difficulties involved. But
4 I would like an opportunity to look at the record a
5 little bit closer, to look at all these doctors'
6 reports again. I would also like you to submit this
7 record to your superiors in Washington, because they
8 have had a number of cases like this in the Criminal
9 Division and the Tax Division as Mr. Block well knows.
10 As long ago as 25 years ago he was arguing this kind
11 of case with me. And they can give us their profes-
12 sional opinion on the subject, given the record we
13 have here. I would like that done. I would like to
14 look at the record myself and look at the doctors'
15 reports, which I for some reason or another, I know you
16 gave them to me at one point.

17 MR. SHANLEY: All the originals were sent to
18 your Honor each time.

19 MR. BLOCK: If you want I can give you those
20 in evidence.

21 THE COURT: You can make xerox copies for me.

22 MR. SHANLEY: The ones in evidence are offered.

23 THE COURT: You can make xeroxes out of it.

24 But you order the record and send it down to Washington
25 and I will study it. I think I am going to ask him to

1 be put in some hospital, probably Kings County Hospital
2 long enough for them to give me a third opinion on it.
3 I don't think I will need a hearing after that. I have
4 a pretty good idea of what is involved here. I just
5 think he may need somebody to look at him for a sustained
6 period of time, which I don't think either of these two
7 doctors had had an opportunity to do.

8 MR. BLOCK: Possibly not.

9 THE COURT: Certainly Dr. Marks indicated he had
10 not.

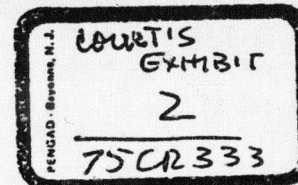
11 MR. BLOCK: No, he saw him twice.

12 THE COURT: And I am not talking just about an
13 hour examination. I am talking about a period of time
14 which would enable them to, over a period of time,
15 determine whether or not he was rational enough and so
16 forth that this didn't interfere with his thinking.

17 MR. STANLEY: Your Honor, we will order the record
18 and submit the photostats of all the documents in
19 evidence to your Honor. And then I would suggest that
20 this Court perhaps set a date for a status report which
21 does not involve the doctors, simply Mr. Block.

22 THE COURT: I will set it up on October 22nd at
23 2 o'clock. And at that time it will be back from Wash-
24 ington and I will have a chance to look at it.

25 MR. BLOCK: October 22nd. Your Honor, will I be



January 31, 1977

Reese F. Alsop, M.D.
North Shore Medical Group
325 Park Avenue
Huntington, L.I., N.Y. 11734

Dear Reese:

Re: U.S. v. William Cooper
74 CR 333

In accordance with our telephone conversation, I am enclosing copies of the following as background information for your examination of the above-named defendant.

1. Copy of the Indictment
2. Letter dated October 7, 1974, addressed to me by Dr. Kenneth Jordan
3. Letter dated September 5, 1974, addressed to defendant's attorney by Dr. Norman L. Chernick
4. Letter dated November 7, 1974, same addressor and addressee
5. Letter dated August 26, 1975, " " " "
6. Letter dated April 9, 1976, " " " "
7. Letter dated October 11, 1976, " " " "
8. Letter dated March 6, 1975, addressed to the Organized Crime Section by Dr. Morton Marks
9. Letter dated May 13, 1976, same addressor and addressee
10. Transcript of hearing before me September 24, 1976

Mr. Cooper's attorney is Mr. Frederick Block of 295 Madison Avenue, New York, New York 10017 [212/685-1161]. Either Mr. Block or Mr. Cooper will call your office to arrange for an appointment at a convenient time.

As we discussed on the telephone, the test stated by the United States Supreme Court in Dusky v. United States, 263 U.S. 402, 80 S.Ct. 788, 789 (1960), is "whether [the defendant] has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding--and whether he has a rational as well as factual understanding of the proceedings against him."

In connection with the first portion of such test, I would want to know whether the defendant is physically able to sit for approximately two hours at a time during the trial and have the ability to consult with his lawyer with a reasonable degree of understanding during such periods. Normally our court day, with 5-10 minute mid-morning and mid-afternoon recesses,

Reese F. Alsop, M.D.
Re: U.S. v. Cooper - 74 CR 333

runs from 10AM to 1PM and 2:15PM to 5PM. If required we could shorten these times.

The defendant contends, as you will gather from reading the background material, that his alleged chronic and intractable pain will compromise his mental state and interfere with his ability to concentrate on the proceedings and thus impair his ability to aid in his own defense.

The government is of the opinion that the evidence as to his pain is entirely subjective.

In essence therefore I would like your view as to whether you think his pain is real and is of such magnitude and of such frequency that he cannot adequately assist in his own defense at a trial.

At the conclusion of your services, please send me a statement therefor and I will arrange to have the same paid.

With many thanks and best regards.

Sincerely,

Thomas C. Platt
U.S.D.J.

Encls.

THE NORTH SHORE MEDICAL GROUP

325 PARK AVENUE

HUNTINGTON, L. I., N. Y. 11743

TELEPHONE: (516) 421-2000

March 7, 1977

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EAR, NOSE AND THROAT

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RADIOLOGY

JOSEPH P. ARCOMANO, M. D., F.A.C.R.
ALAN E. BAUM, M. D., F.A.C.R.

UROLOGY

FRED C. DI BLASIO, M. D.

ADMINISTRATION

WILLETS H. SHOTWELL

The Hon. Thomas C. Platt
United States District Judge
Eastern District of New York
United States Courthouse
225 Cadman Plaza East
Brooklyn, New York 11201

Re: Mr. William Cooper

Dear Judge Platt:

As you can see from the accompanying medical summary, Mr. William Cooper is suffering from a multitude of ills. It is my considered opinion, however, that with good medical management there is no reason why he could not defend himself in court, or consult in a satisfactory manner with his attorney. Although coronary artery disease and duodenal ulcers are adversely effected by stress, I feel that the latter can be cured by a careful medical management, and that the former can be alleviated or controlled.

Hoping this proves helpful, I am

Sincerely,

Reese F. Alsop, M.D.

RFA:ec

CC: Richard L. Shanley, Special Attorney
Frederick H. Block, Esq.

THE NORTH SHORE MEDICAL GROUP

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FRED C. DI BLASIO, M. D.

ADMINISTRATION

WILLETS H. SHOTWELL

Dr. Henry Mednick
50 Hempstead Turnpike
Lynbrook, New York 11563

Re: Mr. William Cooper

Dear Dr. Mednick:

Mr. Cooper states that numerous neurological consultations in New York had resulted in the opinion that he was suffering from a severe causalgia, characterized by pain around the chest margin and in the site of surgical wounds which resulted from two extensive procedures for the correction of a diaphragmatic hernia where the colon was found to be in the chest and adhered to the pleura. Of further concern has been multiple polyps of the colon, treated by Dr. Jerome D. Waye of 1065 Park Avenue, New York, New York by colonoscopy. Although one of the polyps allegedly revealed carcinoma in situ, there was no evidence, at any time, of an extending lesion of a malignant nature. Of further concern is a report on 2/16/77 when the patient had a colonoscopic examination and developed atrial fibrillation with many premature ventricular contractions. He was treated first with Quinidine and then with Inderal and Digitalis by the local cardiologist.

Of further interest in the past history has been pneumonia without complications, and hepatitis in the past without lasting ill effects. The patient had concussion and was treated at St. Vincent's Hospital with convulsions many years ago. There have been no sequelae. The patient is allergic to Penicillin. He is overweight at 206 pounds. He has a complete dental prosthesis. Although the patient had had a past history of peptic ulcers, it was alleged that at the time of his surgery a vagotomy was performed and that duodenal ulcers were therefore not possible at this time. Nonetheless, the patient has classical symptoms of ulcers and is consuming very large amounts of soda bicarb as the powder. In addition, he has a past history of borderline hypertensive cardiovascular disease.

The patient's family history revealed that his father died at 78 of old age. His mother died of heart disease at 70. He has one brother 46, who is well following a myocardial infarction. He has a sister who is 67, living and well. There is no family history of tuberculosis, cancer, diabetes, mental illness, allergy or gallstones or glaucoma, bleeding, migraine, epilepsy, or gout. The patient's habits are model, one cup of coffee, one cup of tea, rare alcohol, no tobacco. He describes himself as a poor sleeper.

THE NORTH SHORE MEDICAL GROUP

Re: Mr. William Cooper

-2-

March 7, 1977

Medications have included Quinidine, as mentioned, Digitalis, and Inderal 10 mg. four times a day. In addition the patient requires Levodromoran at frequent intervals for chest pain.

Physical examination revealed an obese white male, who complained of pain in the left costal margin. His blood pressure was 160/90, weight 203, respirations 14, pulse 90. The remainder of a complete physical examination revealed that he was edentulous, that he had a markedly increased anterior-posterior diameter of the chest with distant breath sounds over the left lower third posteriorly. He had a regular sinus rhythm on examination of the heart with many premature contractions, and a short systolic murmur at the left apex. Sounds were distant. The abdomen was the site of well healed surgical scars. There was tenderness throughout the abdomen of mild degree. The liver, kidneys, and spleen were not felt. The patient had a small indirect inguinal hernia on the right. Rectal examination revealed a normal sized prostate for his years, with brown stool on the examining finger. The extremities showed absent posterior tibial pulses.

Formulation: Although causalgia secondary to his extensive surgery is a real possibility, the presence of multiple large duodenal ulcers, at least three, which appear active and for which he has been taking large amounts of soda bicarb, could well account for his pain. It would be interesting to see what careful ulcer management could achieve. Of further concern is the huge amount of sodium which the patient has been consuming ~~the~~ the presence of borderline hypertension and coronary artery disease with arrhythmias, and of course his multiple polyposis of the colon.

Hoping this proves helpful, I am

Sincerely,

Reese F. Alsop, M.D.

RFA:ec

* The possibility of a soda induced alkalosis being the cause of his arrhythmia should be considered, and justify an electrolyte panel including magnesium.

1
2 hard to isolate one from the other. He gave me a history
3 of having had ulcers in the past which, of course, poses
4 poses to a recurrence, and he described pain in the
5 epigastrium and along the ribs, but this pain is often a
6 manifestation of a peptic ulcer, I couldn't distinguish the
7 two.

8 Q Did he tell you that pain was relieved by
9 soda bicarbonate?

10 A That was my impression.

11 Q You say that was your impression. You mean
12 you could be mistaken as to what he said?

13 A Yes, I could.

14 Q Did he tell you that he was taking
15 Levo-Dromaran, four milligrams every two hours?

16 A Yes, he did.

17 Q Now, if he had pain from ulcers, he wouldn't
18 be taking that kind of medication, would he?

19 A Ulcer pain can be very severe. I've used
20 narcotics in ulcer pain.

21 Q Did he tell you that he had been on this drug
22 for a long period of time?

23 A Yes, he did.

24 Q By the way, isn't that a high dosage, four
25 milligrams of that every two hours?

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A Yes, it is.

Q By the way, wouldn't that have a tendency to dull the mind of the person who is taking it, or aren't you familiar with that effect?

A I've used it a good deal. It's a good narcotic. I used it in terminal cancer patients and I've not been impressed by intellectual clouding as a result of the drug particularly if the person is accustomed to taking it. If you look up in the Physicians' Desk Reference I'm sure it will tell you it would make you woozy, fuzzy-headed. Mr. Cooper gave me a very good history, a very active history, over an hour and a half. He had a good mind and I felt sorry for him, I thought he needed medical care.

Q Doctor, would you disagree if I were to tell you that both Dr. Chernick and Dr. Marks, who was, as I say, the neurologist and psychiatrist selected by the Government, both testified.

THE COURT: Dr. Chernick is your doctor?

MR. BLOCK: I may have misspoken. Dr. Chernick was a doctor of Mr. Cooper's selection; Dr. Marks is a doctor of the Government's selection, they both agreed that this narcotic that we are talking about tends to dull the mind and stated that that would

1
2 have a deleterious effect on Mr. Cooper's ability
3 to consult with his counsel.

4 MR. SHANLEY: That's inaccurate.

5 MR. BLOCK: I'll read the testimony.

6 THE COURT: It's in essence. It's not
7 verbatim what he said. It had some effect --

8 MR. BLOCK: That's right. Both of them said
9 that.

10 My question is: do you disagree with that
11 answer?

12 A No, it certainly could.

13 Q Isn't it true that the ulcer pain comes and
14 goes?

15 In other words, it's not a constant
16 unremitting pain; isn't that correct?

17 A No, that's not correct. It may be unremitting
18 day and night.

19 Q At all hours of the day and night?

20 A It may be, and sometimes we operate for
21 intractable pain in ulcers.

22 Q Are you aware, Doctor, that Mr. Cooper has
23 been complaining of this pain which has been the subject
24 of consultation with these various neurologists ever since
25 1969; you are aware of that?

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A Yes.

Q That's what the history shows?

A That's what the history shows.

Q Don't you find it in some way difficult to understand that in all that time nobody ever diagnosed it as coming from ulcers?

A I think it's very surprising, yes.

Q Does that lead you to question the diagnosis of ulcers?

A No, not the present diagnosis of ulcers, but it would lead me to question the assumption that for five years he had intractable pain as a result of ulcers, because if he had pain because of ulcers it would be very likely he would have developed some of their complications, such as hemorrhage, obstruction or intractable pain; yes.

Q Well, Doctor, now we are talking about from 1969 to date, that's 1977, that's eight years, and the record does show, does it not on the reports that were made available to you, that Mr. Cooper has been complaining of intractable pain during that period of time?

A That is the medical history.

Q Do I understand you to say that kind of thing is inconsistent with your diagnosis of ulcers?

A It's --

Q Let me put it another way.

Are you saying that the pain came from some other source, let us say, up to five years ago, during the first three years, and then during this next five years it came from ulcers; is that what you are saying?

A No. I'm afraid I've been a little unclear. I think Mr. Cooper has had ulcers off and on for that length of time. I think they may well have been the sole cause of his so-called chest pain for that time. I also feel that to say that they have been absolutely consistent without any change in the pain for that period of time is not only difficult for the patient to describe over a long period of time because our memories are fallible. I believe the intensity of his pain has waxed and waned over that period of time, and there is certainly nothing in that history which would in any way conflict with the present diagnosis of ulcers because they are there as big as life. Does that throw any light on the situation.

(continued next page)

Alsup-direct

the years. Sometimes symptoms may have been absent as many as 10 or 15 years but they frequently recur.

Do you agree with that?

A That's well stated. That's a good statement.

Q Isn't that inconsistent, Doctor, with no period of remission as far as Mr. Cooper is concerned?

A It simply says that Mr. Cooper's ulcer hasn't reached the textbook. There are varieties in clinical entities and there is a common statement made by doctors, which is that you never see the textbook case and the variety that is manifested is something that has to be always kept in mind, but I think that's a first-rate paragraph.

Q Even though it could be said, and I guess it's correct, if Mr. Cooper has an ulcer it didn't reach the textbook, that's one thing that I'll agree, but it could be that the diagnosis could be incorrect; it could be?

A Not at present.

Q You mean that's because of what the radiologist found?

A No, that's because of what the radiologist confirmed. There are a host of details. I'm sorry to be difficult about this, but it's a jigsaw puzzle and the pieces have to fall in place including the x-rays and the

described the ulcer crater and pointed them out to me.

Q We don't have that in our report.

A He discusses scar tissue there, deformity of the duodenal cap is the term I think he used.

Q Yes, he does say the duodenal cap itself shows gross deformity and scarring from -- I'm reading from Defendant's Exhibit B -- and scarring from previous ulceration and on the posterior interior wall of the cap a small ulcer crater projects posteriorly and in the same vicinity another ulcer crater projects anteriorly, these are Cushing type ulcers.

A How long after our x-ray was the second one taken?

THE COURT: A matter of days? Just a couple of days, was it?

Q Well, this report -- Doctor Baum's report is dated February 28th, this is dated March 15.

Well, it's almost two weeks, isn't it?

Q Yes.

A Well, I hope Mr. Cooper has been following my therapeutic regimen, this may account for it, but I've seen ulcers healed in that length of time.

Q What was your regimen for him?

A Antacids and stay away from tea, coffee,

1
2 alcohol and spices, and frequent small feedings.

3 Q And that could clear up these three --

4 A In two weeks -- I don't think it could clear
5 them up but it could make them less apparent.

6 Q They could be missed?

7 A I'm very puzzled.

8 Q You are puzzled?

9 A Yes, but I've seen ulcers healed in two weeks.

10 Q Well, if the ulcers have healed -- let's
11 assume for the sake of this moment that he had ulcers and
12 they healed, and that's why they didn't show up on March 15th.
13 Let's assume that. And let's further assume that Mr. Cooper
14 is still complaining about intractable pain in the area
15 that I pointed out to you, in the chest, in the ribs toward
16 the back; would that then lead you to change your view as
17 to his ability to stand trial, that he does have intractable
18 pain not attributable to ulcers?

19 A If I were satisfied that the ulcers were
20 completely healed and that he still had intractable pain,
21 I would certainly feel -- and no longer required aklalai
22 or antacids I would certainly think there would be some
23 other entity accounting for his pain.

24 Q Then we get back to the situation where you
25 would not be in disagreement with Doctor Chernick and Doctor

Marks?

A I still feel that there are -- there is another item to be -- first of all, let me say I'm not convinced that the ulcers are healed.

Q We are making that assumption.

A If you want to assume that they are healed, then one has the problem of his metabolic alkalosis. I want to know whether he's still taking two boxes of soda bicarbonate; that couldn't affect his heart.

Q We are not talking about his heart at this point.

A We are talking about his ability to stand trial.

Q Let me tell you what I'm focusing on. The heart is a separate thing and I'll come to that. What we are focusing on now, here's a man who is suffering from intractable pain, apparently agonizing and he's taking a variety of drugs including -- and I have a list of them, including levo-dromaran, the 4 milligrams every 2 hours.

THE COURT: I think you have to put the question to the doctor, assuming.

Q Yes, assuming he takes 100 milligrams of hydrotone, that's for high blood pressure, and these are daily doses, and he takes two doses of seconal, he takes

two doses of tylenol every two hours; he takes K-Lite potassium supplement daily; he takes endoral, 60 milligrams a day, and the endoral is for coronary disease; correct?

A And high blood pressure.

Q And the tylenol is sort of like a tranquilizer?

A Pain killer.

Q The second is to help him sleep; is that right?

A Yes.

Q He takes dajoxin (phonetic) 25 bw.

A .25 milligrams a day.

Q And that is for the control of fibrillation condition that he has?

A The combination.

Q Right. And as I understand it, the potassium chloride, that is the K-Lite offset -- so he's a walking pharmaceutical store. And as I say on the assumption that we are talking about, that he takes all this medication, assume that he suffers intractable agonizing pain, do you think that he could sit in a courtroom and consult with his counsel and help in his defense, that's what it really comes down to.

Assuming that he has intractable pain, and assuming that his ulcer is completely healed and that he

1
2 still requires the degree of medication you delineated,
3 I think it's fair to say that he would have trouble with his
4 defense.

5 Q And actually none of this medication that he
6 takes has anything to do with an ulcer condition, it's all
7 unrelated?

8 A Sedation is one of the routine prescriptions
9 for ulcers and secondal to help him sleep; the tylenol would
10 help the ulcer pain; particularly it's customary to give
11 some sedation to people who are very tense and have an ulcer.

12 Q All right. Is there anything, sir, to the
13 belief that it is tall, thin people who suffer from ulcers
14 rather than persons who are somewhat inclined to obesity, as
15 Mr. Cooper is?

16 A Yes, the tall, thin Abe Lincoln type is more
17 prone to ulcers, but by the same token, patients with
18 emphysema are also prone to ulcers. Mr. Cooper has a --

19 Q You didn't say anything about emphysema in
20 your report, did you?

21 A No. I didn't want to label the man with too
22 much -- distant breath sounds over the lower third posteriorly
23 which are findings consistent with a motor, or very small
24 amount of emphysema.

25 Q Could it be that that condition is attributable

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2 Q As a matter of fact, you had them for several
3 days and Mr. Cooper ultimately came to pick them up?

4 A Yes.

5 Q Did they show, if you recall, if you have any
6 notes, that there was something like 17,000 extra beats over
7 what should be normal or -- I'm not quarreling with the
8 17,000. It showed atrial fibrillation?

9 A Which had been corrected actually by -- yes,
10 he had atrial fibrillation and then the cardiologist improved
11 the situation, so that my own cardiogram, by the time I took
12 a cardiogram showed a first degree block -- without getting
13 too complicated -- my electrocardiogram showed very considera-
14 ble improvement in response to the treatment by the heart
15 man.

16 Q Let me ask you this. Is it fair to say that
17 Mr. Cooper in addition to everything else he's got is suffer-
18 ing from coronary artery disease?

19 A I think one is justified in a high index of
20 suspicion, but I don't think it's been completely confirmed
21 because I can't find any record of electrolytes being taken;
22 electrolytes are important before you finally make that diag-
23 nosis, but I would say in my opinion at the present time there
24 is a 90% chance that he has coronary artery disease; not 100%.

25 Q Now Doctor, let's just talk about this.

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2 diagnostic of duodenal ulcer as far as three board-
3 certified radiologists were concerned had no symptoms
4 at all suggestive of duodenal ulcer."

5 A In other words, the ulcers were there without
6 any symptoms, which is what I described before, the silent
7 ulcer. I told you that I had a patient who hemorrhaged from
8 an ulcer without any symptoms at all.

9 THE COURT: Isn't that 29 per cent of 8 per cent?

10 MR. BLOCK: 29 per cent of patients with --

11 THE COURT: And only 8 per cent -- says 29
12 per cent of 8 per cent.

13 Q In any event, doesn't it indicate in your
14 opinion that the radiologists were wrong?

15 A No. That was the point I wanted to make.

16 Q I see. Just one second.

17 I must come back to this, Doctor. You said you
18 didn't agree with me when I said when we got to the point of
19 suggesting that there could be two pains, right?

20 A I am sure there could be two pains.

21 Q Now, if we say one pain comes -- if we assume
22 that your radiologist is right and that Mr. Cooper's
23 radiologist is either wrong or there was a drastic improvement
24 as a result of the treatment which you prescribed, you know in
25 the two-week period, but we are assuming that he does have an

1 ulcer or three ulcers, as you say, but if we assume that he
2 has the other pain, pain No. 2 causing intractable pain in
3 this area of the left chest towards the back which Dr. Chernick
4 and Marks talked about and said they were satisfied about
5 objectively, then what I am asking you is whether you agree
6 that he should not be put on trial in light of that because
7 that was a conclusion of both Dr. Marks and Chernick, both
8 agreed that it wouldn't endanger his life.
9

10 MR. SHANLEY: Objection.

11 THE COURT: I understand what Chernick and
12 Marks said.

13 MR. BLOCK: I want the doctor to know what I
14 said.

15 THE COURT: You slightly overstated it. He
16 read it, too.

17 Q All I'm asking is if we say that there are two
18 pains, we make that assumption, then I ask you if you didn't
19 agree with the evaluation of Dr. Marks and Chernick and you
20 said you didn't, I would like to know why.

21 A Perhaps it's simply a question of semantics.
22 If one assumes that I am right as far as the ulcer is
23 concerned, and also assume that the neurologists is right in
24 their contention, we have two pains; and if those two pains
25 are going to continue without amelioration, one could say that

1
2 this would be a very real hardship for the patient in his
3 defense, but if one of the pains can be alleviated, as I
4 strongly suspect, assuming all these things, then one might
5 argue that the patient could well manage his defense. We are
6 making a lot of assumptions.

7 Q I see what you are saying. We are talking about
8 pain No. 2 emanating, trouble with the ribs, and we have seen
9 documentation of that pain going back to 1969 and causing this
10 man a great deal of pain.

11 A I think the confusion, you know what I think the
12 confusion is: It's very hard for you, me and very hard for
13 Mr. Cooper. The truth of the matter is one can't distinguish
14 with the nicety that one would like to between the two pains.
15 I would like to assume the neurologist is correct, I would like
16 to assume my roentgenologist and I are correct, but it's very
17 hard to make a very clean-cut distinction between these two
18 pain entities because they are both relatively close
19 geographically and we know that there is a tremendous
20 variation in the pain pattern of ulcers, and I am sure any
21 neurologist would agree there is variation in the pain of
22 causalgia to put one thing in one department, put one thing
23 in the other department. My thing is to clear up the ulcer
24 thing completely and then see how his causalgia responds or
25 doesn't respond. Is that logical?

THE NORTH SHORE MEDICAL GROUP

325 PARK AVENUE

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ALAN E. BAUM, M. D., F.A.C.R.

UROLOGY

FRED C. DI BLASIO, M. D.

ADMINISTRATION

WILLETS H. SHOTWELL

April 18, 1977

Hon. Thomas C. Platt
United States District Court
Eastern District of New York
225 Cadman Place East
Brooklyn, New York 11201

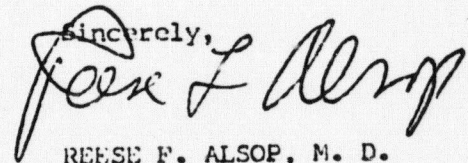
Dear Judge Platt:

As you can see from the accompanying medical summary, Mr. William Cooper presented himself to my office today, April 18th, for further followup of his medical ills. He describes some improvement in his digestive symptoms but stated that his causalgia was essentially the same in spite of 4 mgms. of Levo-Dromoran every two hours.

Re-examination of Mr. Cooper revealed no new findings, and I am still of the conviction that there is no reason why he cannot defend himself in court or consult in a satisfactory manner with his attorney, provided adequate and careful medical supervision of his problems is maintained.

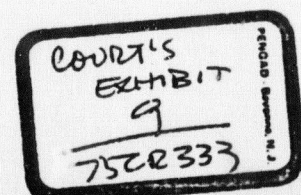
Hoping this proves helpful, I am

Sincerely,



REESE F. ALSOP, M. D.

RFA:mbt
enc.



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ADMINISTRATION

WILLETS H. SHOTWELL

April 18, 1977

Dr. Henry Mednick
50 Hempstead Turnpike
Lynbrook, New York 11563

RE: Mr. William Cooper

Dear Dr. Mednick:

I've re-examined Mr. William Cooper April 18, 1977 as a followup to my original evaluation, reported to you on March 7th of this year.

Mr. Cooper reports some vague improvement in his digestion symptoms, but states that his subjective complaint of causalgia remains unabated in spite of 4 mgms. of Lavo-Premeran every two hours. He has apparently gone to very considerable lengths to challenge the diagnosis of duodenal ulcer. He brings in reports from a Dr. Lawrence Ross and a Dr. Harry Naldich. In both of these roentgenological reports, acknowledgement of the deformity of the duodenal bulb is clear, but both men surprisingly stress the absence of tenderness and/or postprandial stress or relief by the ingestion of food. This, in a patient who is on apparently huge doses of a narcotic which would successfully drown out the usual symptomatology and findings.

Physical examination revealed a lucid, pleasant, obese white male who's in good contact, with a blood pressure of 180/80, a pulse rate of 80 with a ventricular rate of 90, a deficit of 10. His respiratory rate was 14. His chest was as previously described, and examination of his heart showed a regular sinus rhythm with many premature contractions. There was no edema of the ankles.

Formulation: I have nothing to add to my summary of March 7th which is in your hands. Certainly, I am sure that you will agree weight loss and careful supervision of his cardiovascular system, with continued management of peptic disease, are all indicated as are the removal of his allowed polyps.

cont'd.

THE NORTH SHORE MEDICAL GROUP

RE: [REDACTED]

Mr. Cooper does not impress me as a man who is unable to deal with his lawyer or give testimony in spite of the multitude of his ills.

Hoping this proves helpful, I am

Sincerely,

REESE F. ALSOP, M. D.

RFA:mt

LAWRENCE R. ROSS, M.D., P.C.
206 E. 30TH STREET
NEW YORK, N. Y. 10016
TELEPHONE 686-2220

LAWRENCE R. ROSS, M.D., F.C.C.P.

April 6, 1977

Frederick H. Block, Esq.
919 Third Avenue
NYC, NY 10022

Dear Mr. Block:

At the request of Mr. William Cooper I have taken his history as it relates to his gastrointestinal tract, and I have reviewed the upper GI series, taken on March 14th and March 21st, with particular attention paid to the lower esophagus, stomach and duodenum.

Mr. Cooper had a repair of a hiatus hernia in 1969 and a pyloroplasty and vagotomy during the same procedure. The patient presents with a classic history of peptic esophagitis which apparently is secondary to a reflux from a patulous esophago-gastric junction, proven during x-ray studies. He takes frequent doses of antacids to relieve this discomfort which is located primarily in the substernal area, and is non-radiating. He has no symptoms which can be construed as being due to a peptic ulcer. In particular, the patient does not experience pain occurring prior to meals, there is no epigastric location of the heartburn type of pain, and indeed the pain is not relieved in particular by the ingestion of food. There is no tenderness located over the epigastrium. The x-rays themselves reveal a clover-leaf deformity of the duodenal bulb and on several films there is what can be construed as a filling

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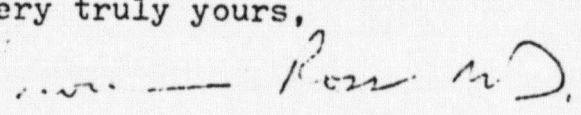
LAWRENCE R. ROSS, M.D., F.C.C.P.

defect in the bulb suggestive of a small polypoid mass. There is no definite evidence of a duodenal ulcer; the clover leaf deformity which is present is indicative of scarring secondary to old "burned out" ulcer disease, but with no evidence of active ulceration.

It is my opinion that Mr. Cooper suffers from peptic esophagitis and has evidence for having had active duodenal ulcer disease in the distant past. Neither of these entities can in any way be construed as being related to the almost constant pain and tenderness which he experiences in the left posterior axillary region over the rib cage. Neither peptic ulcer disease nor peptic esophagitis causes a patient to experience pain in the area where it is experienced by Mr. Cooper.

Should you require any additional information I would be happy to furnish it.

Very truly yours,


Lawrence Ross, M.D.

LAWRENCE R. ROSS, M.D., P.C.
206 E. 30TH STREET
NEW YORK, N. Y. 10016
TELEPHONE 686-2220

April 28, 1977

LAWRENCE R. ROSS, M.D., F.C.C.P.

Mr. Frederick H. Block, Esq.
919 Third Avenue
NYC, NY 10022

Re: William Cooper

Dear Mr. Block:

I have reviewed in detail the medical reports of Dr. Richard Hamilton, Dr. Harry Naidich, both Radiologists, and Dr. Allen Baum. I have also reviewed the neurological reports of Dr. Arthur Battista, Dr. Norman Chernik, and Dr. Joseph Ransohoff. In addition, I, myself, have evaluated Mr. Cooper from both gastro-intestinal & neurologic bases.

There is no doubt that Mr. Cooper has suffered from chronic peptic ulcer disease in the past, nor is there any doubt that Mr. Cooper suffers from intractable pain, poorly relieved by analgesics, including morphine derivatives, at the present time. This pain is due to a post-thoracotomy thoracic root syndrome, entirely unrelated to his gastro-intestinal disease.

Mr. Cooper is unable to adequately participate in his defense, and stand trial, since he is in constant, intractable pain and is on continuous medication with morphine derivatives as well.

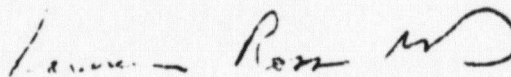
LAWRENCE R. ROSS, M.D., P.C.
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TELEPHONE 686-2220

LAWRENCE R. ROSS, M.D., F.C.C.P.

There is great doubt as to whether medical science would be in any way able to alleviate Mr. Cooper's problems. Many therapeutic modalities have been utilized since 1969, with no improvement of either a subjective or objective nature.

Should you require any additional information, I would be happy to furnish it.

Very truly yours,



Lawrence Ross, M.D.
(Fellow, American College
of Chest Physicians)

LRR: bkg

MEMORIAL SLOAN-KETTERING CANCER CENTER

1275 YORK AVENUE, NEW YORK, NEW YORK 10021

(212) 879-3000



April 27, 1977

Frederick H. Block, Esq.
919 Third Avenue
New York, New York 10021

Re: William Cooper

Dear Mr. Block:

In response to your request, I have reviewed the medical report of Dr. Reese F. Alsop re: Mr. William Cooper.

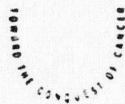
Dr. Alsop has concluded that the intractable pain which Mr. Cooper suffers from is due to three large duodenal ulcers. This is in direct contradiction to my own as well as other expert witness testimony which has been outlined to the court previously. I would like to point out several discrepancies in Dr. Alsop's conclusion. First of all, Dr. Alsop apparently has ignored the temporal and anatomic profile of Mr. Cooper's complaints. Onset of the pain immediately followed thoracic surgery in 1969. Symptoms have continued unabated from that time to the present. The pain is aggravated by postural changes. There is marked tenderness along the T₆ - T₇ dermatomes overlying the site of the surgical incision. These points outline an anatomic as well as temporal profile which would make it inconceivable on a neuro-physiologic basis that Mr. Cooper's intractable rib pain is due to ulcer disease. In support of this Mr. Cooper has subsequently been examined by additional experts in the field of neurosurgery. He was examined by Dr. Arthur F. Battista, Professor of Neurosurgery, New York University, on April 14, 1977. Dr. Battista's report notes that Mr. Cooper's history and examination is consistent with intercostal neuralgic like pain syndrome which is related in time to the operative procedure in 1969. He further points out that this type of pain is extremely difficult to treat effectively. The patient has also been more recently examined by Dr. Joseph Ransonhoff, Professor of Neurosurgery, New York University. I do not have Dr. Ransonhoff's written report but verbal communication substantiates that there is absolutely no relation to the chronic intractable pain involving Mr. Cooper's left rib cage to any possible abdominal process.

A 53

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April 27, 1977

I would also like to take this opportunity to point out that Dr. Alsop's report to the court surprisingly failed to mention a neurologic evaluation even to the extent that he failed to note the presence or absence of tenderness of the involved rib cage or the presence or absence of the hemisensory deficit which is a prominent feature of the neuralgic syndrome which he suffers from. In the absence of their mention, I can only conclude that that aspect of the examination was not performed. It is therefore even more indefensible for a conclusion to be drawn discounting the neurogenic origin of Mr. Cooper's complaint.

It is also important to emphasize that Dr. Alsop's conclusion is largely if not totally based upon the x-ray report provided to him by Dr. Allen E. Baum, who performed the radiologic evaluation of Mr. Cooper upon Dr. Alsop's request. Dr. Baum reported that there was deformity of the pyloric canal and duodenal cap with marked scarring from previous ulcer disease and in addition there were two ulcers immediately adjacent to each other, one being located on the inferior-posterior wall of the duodenal cap. Dr. Baum notes that the ulcer on the inferior-posterior wall of the duodenal cap was small and did not note the size of the ulcer adjacent to it. He does not make mention of a third active ulcer in that report. It must be emphasized to the court that two other consultant radiologists have differed from the opinion provided by Dr. Baum to Dr. Reese Alsop. Dr. Harry Nadick performed an upper gastrointestinal tract barium study two weeks following the examination by Dr. Baum and specifically concentrated on the area in question. He also noted distortion in the anatomic contour related to chronic ulcer disease and also raised the question of whether or not there may be a pseudodiverticulum involving that area. He was not able to demonstrate active ulceration. On April 20, 1977 Dr. Richard Hamilton reviewed the x-rays submitted to the court by both Dr. Nadick and Dr. Baum. Dr. Hamilton's report emphasizes a chronically deformed and scarred duodenum without evidence of active ulceration. However, I would like to emphasize that although Dr. Baum's original conclusions regarding active ulcer disease has been challenged by both consultants, I would not like to rest the argument on the presence or absence of active ulcer disease. For as I noted in the above paragraph, even if active ulcer disease is present it would not manifest itself by intractable pain involving the rib cage which is exacerbated by mechanical movement

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April 27, 1977

and external pressure, which remained intractable to all attempted modalities of pain relief including nerve blocks, and which has a temporal profile that clearly relates it to thoracic surgery performed in 1969.

If there are any questions regarding the above I will be very happy to discuss them further with you.

Sincerely,

Norman L. Chernik, M.D.
Associate Attending Neurologist
Associate Attending Neuropathologist
Memorial Sloan-Kettering Hospital
Associate Professor of Neurology
Cornell Medical School

NLC/wp

A 55



NEW YORK UNIVERSITY MEDICAL CENTER

School of Medicine

550 FIRST AVENUE, NEW YORK, N.Y. 10016

AREA 212 679-3200

CABLE ADDRESS: NYUMEDIC

Department of Neurosurgery

April 22, 1977

Lewis Lawrence, M.D.
Lakeville Radiology Association
Lakeville Medical Bldg.
2035 Lakeville Road
New Hyde Park, New York

Re: William Cooper

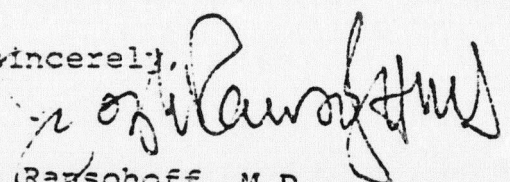
Dear Lawrence:

I saw Mr. Cooper in the office with interest. This unfortunate gentleman has a classical postthoracotomy thoracic root syndrome. This is one of the well known complications following transthoracic surgery for repair of hiatus hernia or for other thoracic surgical problems. It is strictly unilateral and follows a classical root distribution. I mention this in view of the fact that some question has been raised as to whether the etiological basis for the pain was that of a gastric or duodenal ulcer. In my opinion, there is no way that a gastric or duodenal ulcer could produce this type of strictly unilateral pain of a classical nerve root distribution. I gather, however, that his G.I. series showed no active ulcer so that the issue is really no longer pertinent.

He has had a number of attempts at pain relieving procedures. My recommendation to him was that he be seen in consultation by Dr. Hubert Rosomoff, Chairman of the Department of Neurosurgery at the University of Miami, Jackson Memorial Hospital. Dr. Rosomoff is the world authority on the use of percutaneous radio frequency chordotomy. I am fully convinced from my own experience that thoracic root section would not relieve his problem and it would be my feeling that Dr. Rosomoff who has had very extensive experience might feel that a simple radio frequency lesion could offer him good relief.

I hope these recommendations meet with your approval.

Very sincerely,


Joseph Rosomoff, M.D.
JR:lc

A 56

1 That's it, your Honor, and I think in light of
2 all of this, that there really is no substitute for
3 further testimony and --

4 THE COURT: Well, I'm prepared to make a ruling.
5 I appointed an independent doctor, of the Court's own
6 choosing, for the express purpose of getting an
7 independent view, rather than a partisan view. The
8 Court has great confidence in Dr. Alsop, as I am sure
9 you are aware.

10 I advised the parties prior to the initial
11 examination by Dr. Alsop, at my choice, and you have
12 known my choice. No objection was raised at that time
13 of my choice. He conducted an examination. He testi-
14 fied here in Court. The hearing, my recollection,
15 unless it shall be faulty, lasted for about two hours,
16 during which time the Court had an opportunity to
17 observe the defendant assisting his counsel, not only
18 incidentally, but quite actively during the hearing,
19 at which time Dr. Alsop was examined and cross-examined
20 at length by defense counsel.

21 The Court, on the basis of its own observations,
22 is prepared to make an observation. Of course, Dr.
23 Alsop has made two independent findings, after two
24 examinations of this defendant, that this defendant
25 has more than sufficient present ability to consult

1 with his lawyer, with a reasonable degree of rational
2 understanding, and that he has a rational as well as
3 factual understanding of the proceedings going against
4 him, which is a test set down on Duffy against U.S.;
5 U.S. 408, 1950.

6 Under those circumstances, I am going to deny
7 the defendant's application, that he is incompetent,
8 to, by reason of disability, to stand trial.

9 What date do you want, Mr. Ritchie? Monday?

10 MR. RITCHIE: I don't believe so, your Honor.
11 The case has to be reassigned. At the time that the
12 United States submitted its notice of readiness, it
13 had asked, because of the nature of the case, for 14
14 days prior notice.

15 THE COURT: The 9th?

16 MR. RITCHIE: That was with an attorney who had
17 been handling the case from its inception.

18 THE COURT: I said May 9.

19 MR. RITCHIE: Your Honor, I really don't
20 believe the Government can be ready. Mr. Shanley is
21 just about -- he's really disengaging himself from the
22 office. He will be gone as of May 6th.

23 THE COURT: This is a simple tax case? How
24 long will it take to prepare?

25 MR. RITCHIE: It's an TSE --